# Pre-Seminar Quiz

# Key diagnostic features of dementia are:

A. Interference with social/executive functioning
B. Fluctuating level of consciousness
C. Memory loss/impairment
D. A & C
E. None of the above

# Patient has normal MMSE score. The likelihood of this patient having dementia is:

A. Low, less than 5%
B. Relatively high, 25% or greater
C. Uncertain due to educational attainment
D. A and C
E. None of the above

# Routine lab evaluation for initial evaluation of suspected dementia include

A. Thyroid function tests
B. CBC, chemistry, RPR, lumbar puncture, lyme
C. B12 levels
D. A, B and C
E. A and C

# Conditions mimicking dementia “reversible dementias”

A. Hypothyroidism
B. Depression
C. B12 deficiency
D. A, B, and C
E. A and C

# Questions before we begin?

# Why is this seminar relevant to me?

- COL. Unwin tells me so
- I have to do this to graduate
- Important to my patients
- Important to my parents
- I want to do well on wards
- I want to be able to write intelligent consults
- This may be me some day

# Introduction to Clinical Medicine III- Introduction to Clinical Geriatrics

COL Brian Unwin, M.D.
Department of Family Medicine, USUHS

# Introduction: Geriatrics will be part of your practice:

- Aged >65 are 14% of our population in 2010, and 25% in 2050
- Age >85 will be 5% of our population in 2050
- 33% of our office visits, becoming 50% of our office visits
- Accounts for 1/3 of our health care dollar

# Common Clinical Problems in Geriatrics are Syndromes:

- Impotence
- Incontinence
- Incoherence
- Irritable bowels
- Insomnia
- Isolation
- Impecunity
- Immune deficiency
- Immobility
- Instability
- Intellectual impairment
- Infection
- Impairments
- Inanition
- Iatrogenesis
- Illiteracy

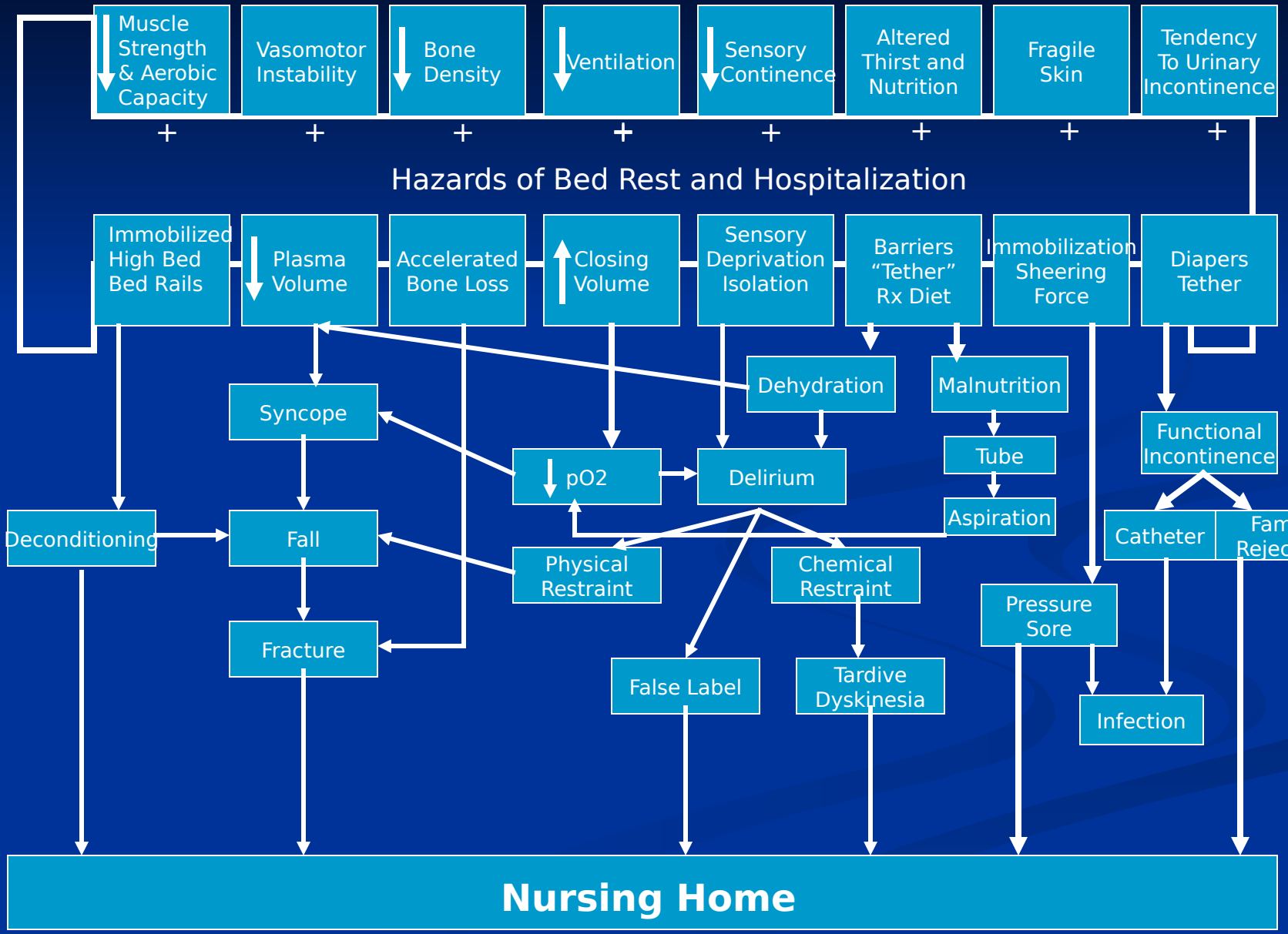
# Quality of Care to the Aged:

- Adherence to Quality of Care Indicators is less for geriatric conditions than general medical conditions
  - 31% vs 52%
- Biggest problem areas were
  - Urinary incontinence
  - End-of-life care
  - Falls and mobility
  - Medication management

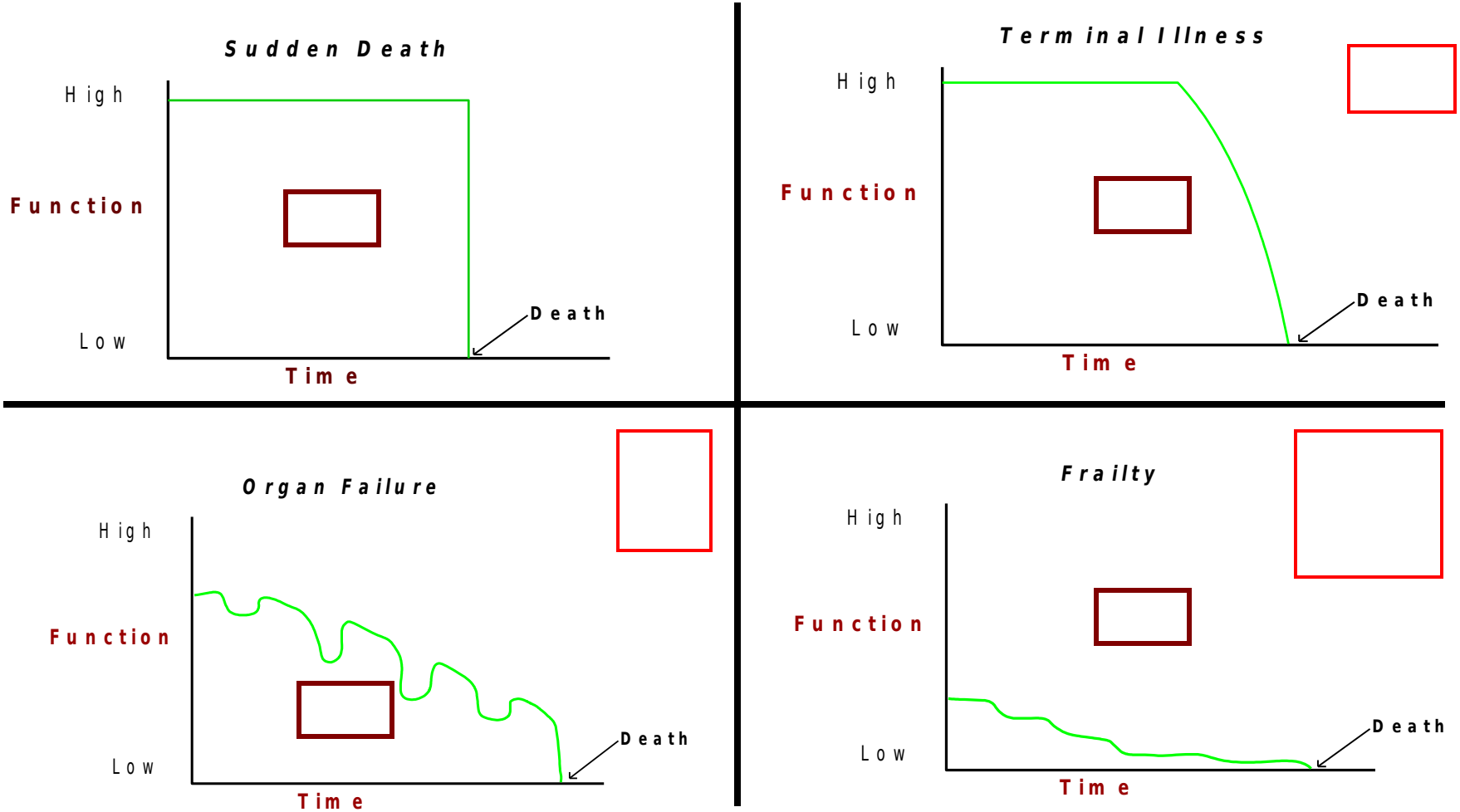
# Our Roles in Geriatric Health Care:

- Delay disability and dependency
- Maximize function and autonomy
- Enhance coping ability
- Understand functional status as well as diagnosis
- In summary: CARE, RARELY CURE

# Cascade to Dependency



# Trajectories of Dying




Lunney, JR, Lynn J, Hogan, C. Profiles of Older Medicare Decedents. JAGS 50:1108-1112, 2002

# Geriatric Seminar Topics:

- Memory
  - Cognitive Assessment Concepts and Tools
- Mood
  - Identification and Treatment of Mood and Behavioral Disturbances
- Failure to Thrive
  - Identification of Functional Impairments and Malnutrition

# Why use standardized tests?

- Quantifies difficult to measure conditions
- Supports/refutes diagnosis
- Supports/refutes treatment
- “Common Language” among providers
- Consistent/reproducible
- Decrease inter-rater variability
- Research

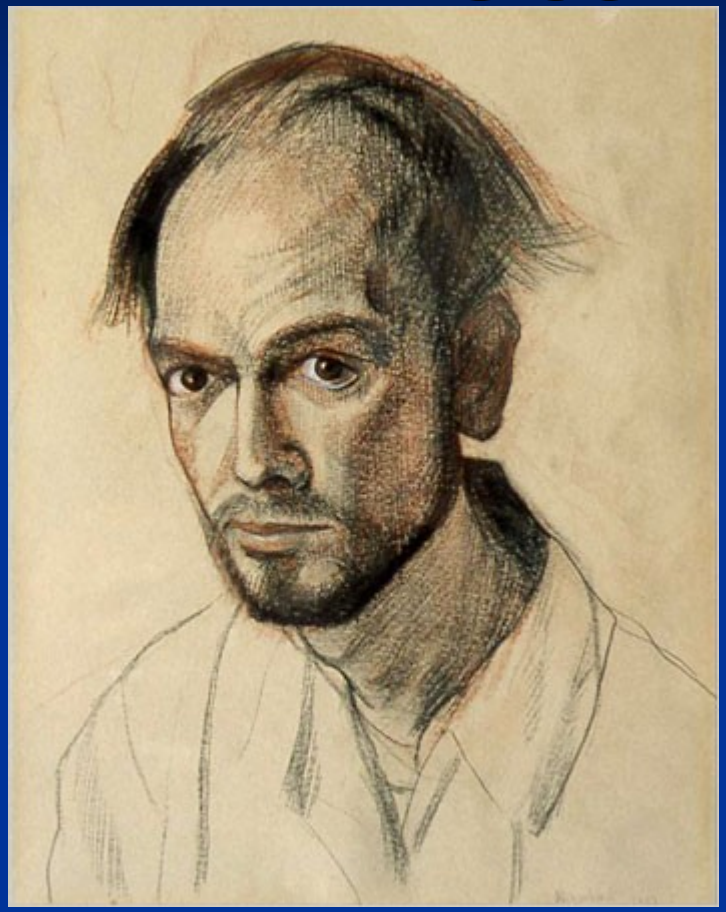
# Flow of the afternoon

- PreTest (Reading Completion)
- Additional Material
- Demonstrate conduct of:
  - MMSE and Clock Draw
  - Geriatric Depression Screen
  - Timed Up and Go
  - Standing Reach
  - Shower and Shoes test
  - Nutrition Assessment
- Introduction of the case
- Students practice the above
- Feedback

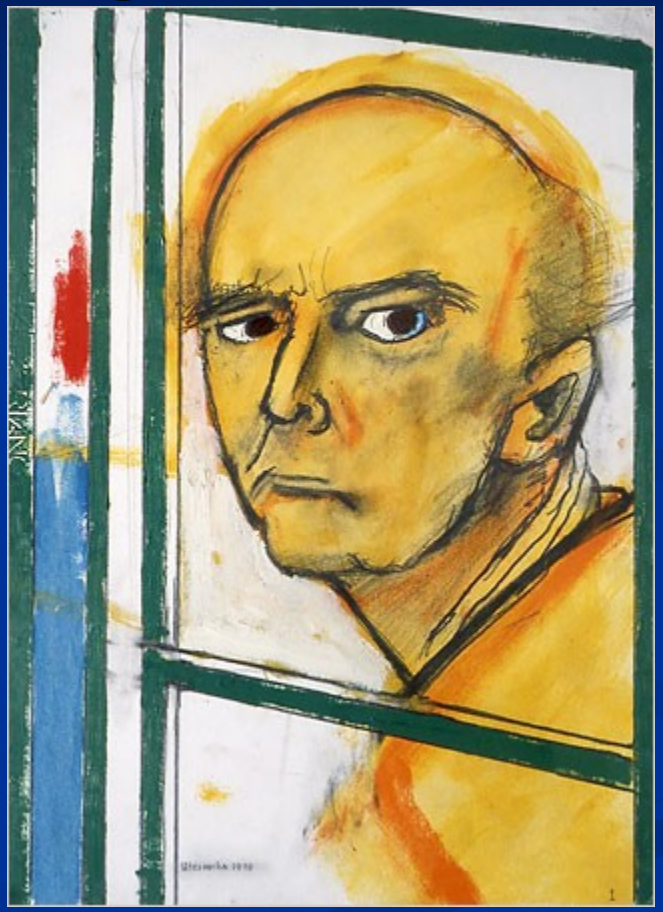
# Memory and Cognitive Disorder Assessment

Curriculum Development:
COL Brian Unwin, MD
Department of Family Medicine, USUHS

# Descent into dementia—the paintings of William Utermohlen



1967



1996

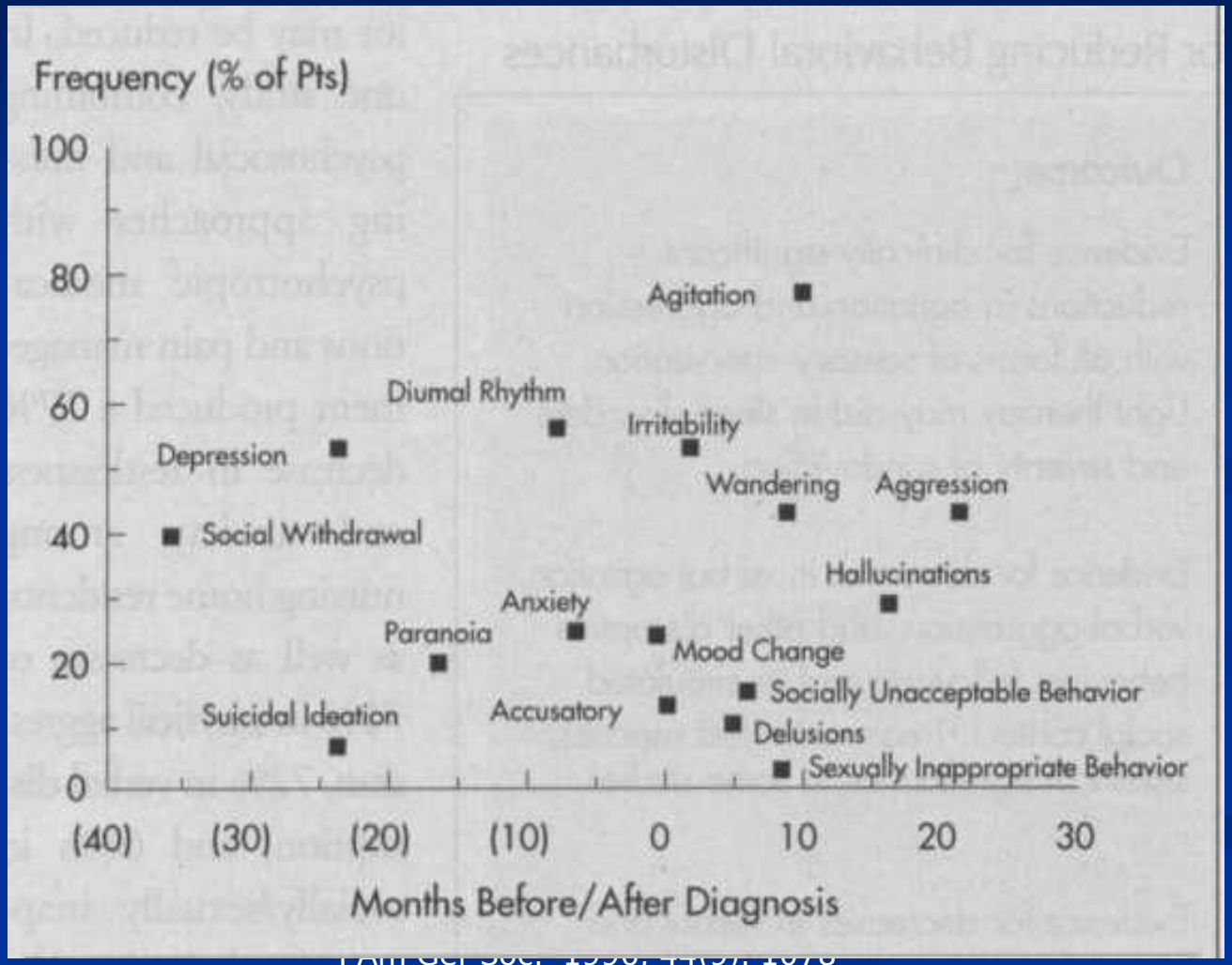
# *DSM-IV* DIAGNOSTIC CRITERIA FOR AD:

- Development of cognitive deficits manifested by:
  - Impaired memory **AND**
  - **Aphasia** (comprehension or production of language) OR
  - **Apraxia** (loss previous motor skill) OR
  - **Agnosia** (object recognition) AND/OR
  - **Disturbed executive function**
- Significantly impaired social, occupational function
- Gradual onset, continuing decline
- Not due to CNS or other physical conditions (e.g., Parkinson's, delirium)
- Not due to an Axis I disorder (e.g., schizophrenia)

# MISSING from DSM IV Criteria

- Behavior and mood changes
- Delusions, hallucinations, aggression, wandering

# Behavioral Disturbances in Dementia:




J Am Ger Soc. 1996; 44(9): 1078-1081

# Behavioral Disturbances

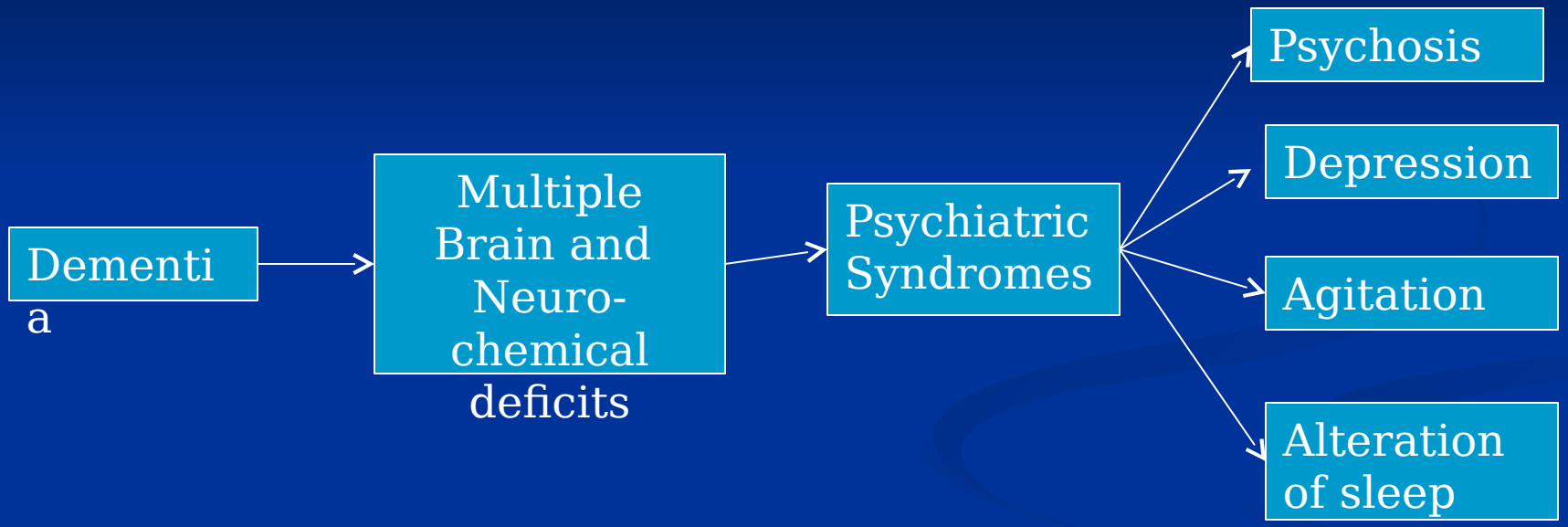
- Agitation
  - Global 44%
  - Verbal 24%
  - Physical Aggression 14%
- Apathy/negative symptoms 61%
- Depressed mood 19%
- Psychosis
  - Delusions 34%
  - Hallucinations 28%
  - Misperceptions 23%

Tariot P. J Clin Psych. 1996: 57(suppl 14): 21-49. others

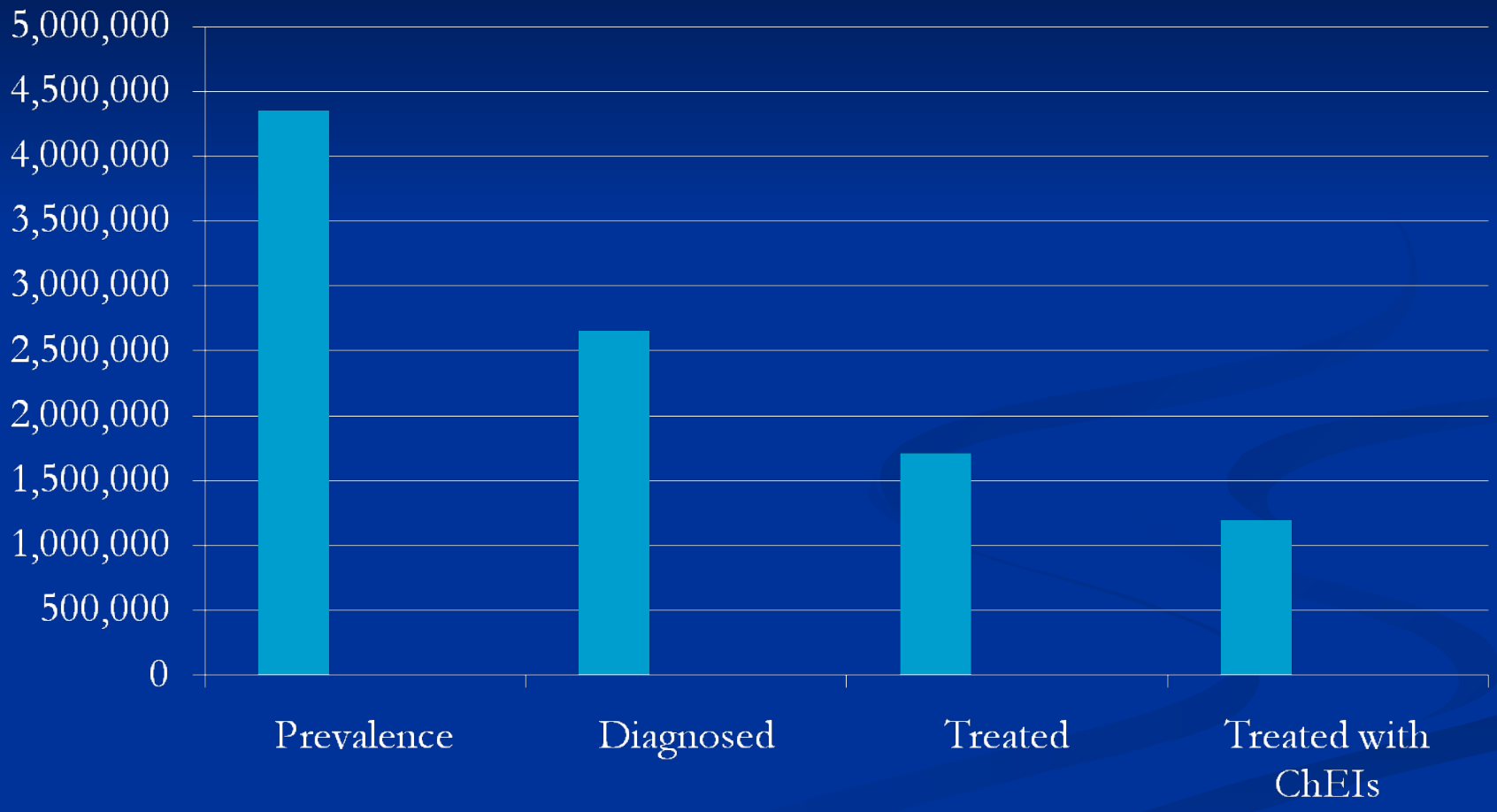
# What is Agitation?

- Inappropriate verbal, vocal or motor activity that is not explained by apparent needs or confusion

# Psychiatric Syndromes of Dementia



# Underdiagnosed and Undertreated



# Neuropsychiatric Inventory

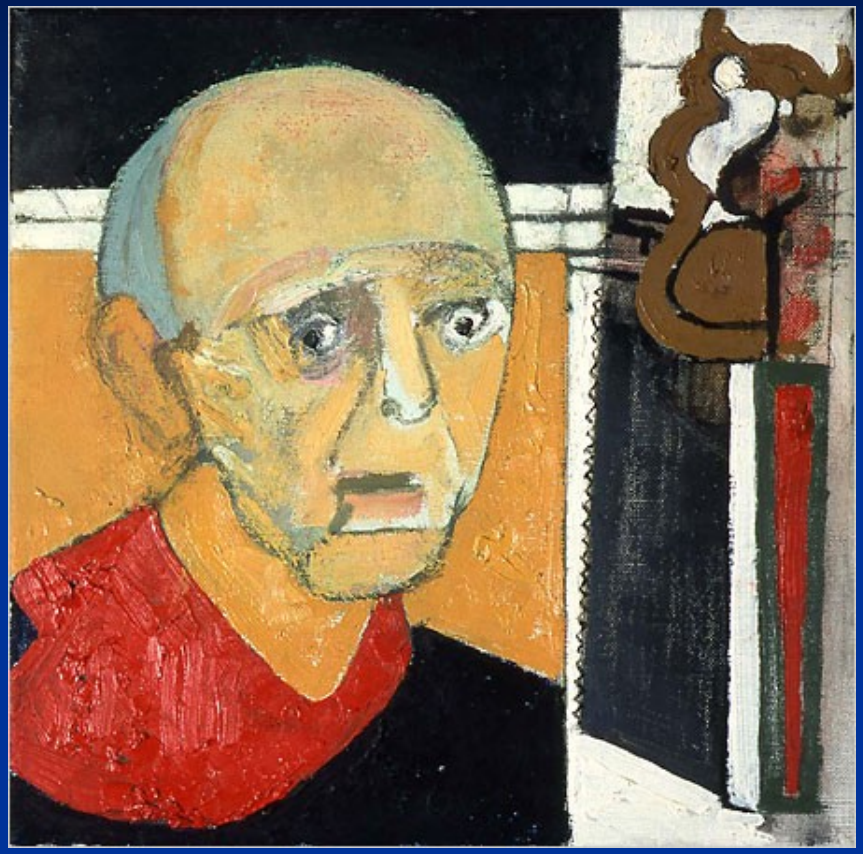
Assess frequency and severity of behaviors:

| Delusions | Hallucinations | Agitation |
|---|---|---|
| Depression | Anxiety | Euphoria |
| Apathy | Disinhibition | Irritability |
| Aberrant motor behavior | Nighttime behaviors | |
| Appetite and eating disorders | | |

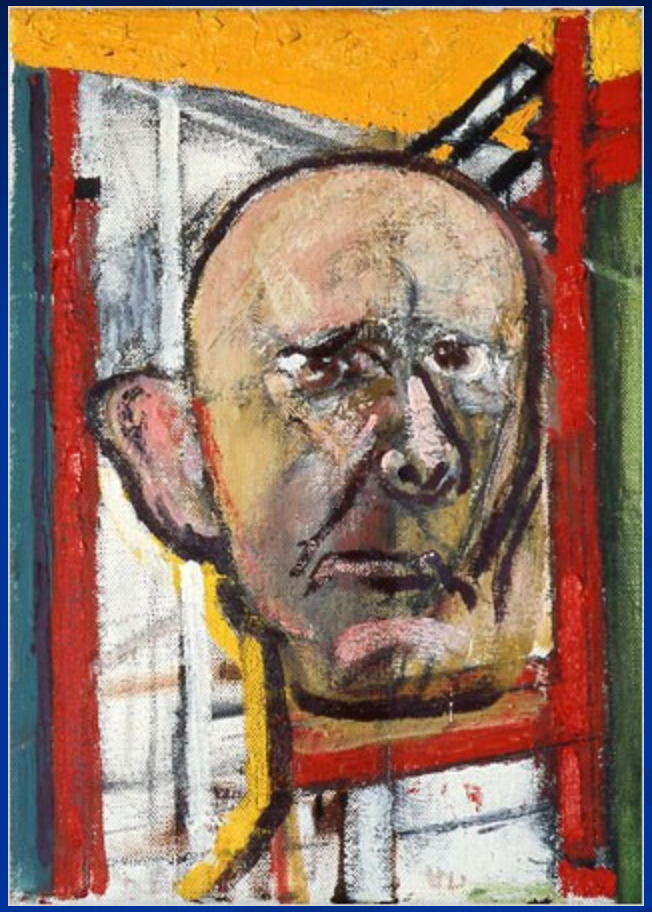
Cummings JL, Neurology, 1994; 44:2308-2314

# Types of Behavior:

- Catastrophic reactions
- Wandering
- Repetitive questions or actions
- Sleep disturbance
- “Sundowning”
- Inappropriate sexual contact
- Losing items
- Hoarding items
- Clinging
- Insults
- Demanding behavior
- Uncooperative/ stubborn



1997

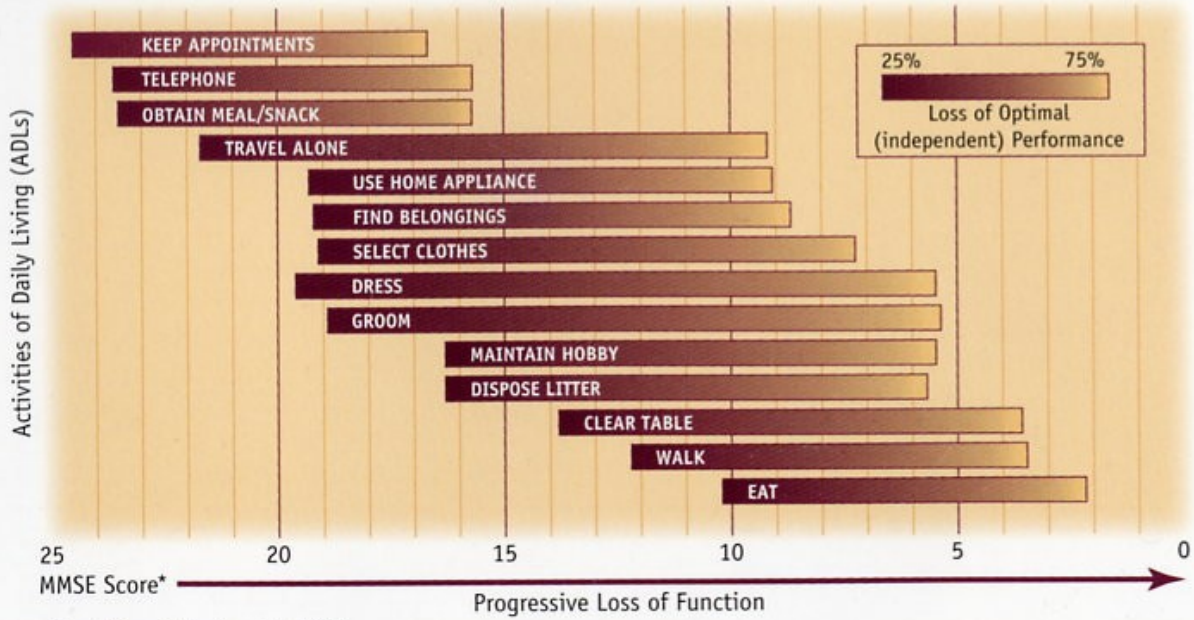


1998

# Function and Mental Status:

## MMSE* Scores Correlate With Ability to Perform Daily Activities (ADLs)[3]

*Each bar represents from left to right the range of MMSE scores over which 25% to 75% of Alzheimer's patients in one study showed loss of optimal (independent) performance of ADLs at 12 months* [3,4,†]




Adapted from Galasko et al, 1997.[3]

*Mini-Mental State Examination (MMSE)—a 30-point scale for evaluation of cognitive function.

† A multisite study examined efficacy measures for Alzheimer's disease in individuals with normal cognitive function and in patients with dementia across the spectrum of disease severity; lower MMSE scores correlated with declining ability to perform selected ADLs.[3,4]

# Treatment of Behavior Problems and Functional Losses: Caregiver Support

- Gentlecare: Changing the experience of Alzheimer's Disease in a positive way
  - Moyra Jones, Hartley and Marks, 1998
- Practical Dementia Care (2nd Edition)
  - PV Rabins, Oxford Press, 2006
- The 36-Hour Day: A Family Guide to Caring for Persons with Alzheimer's Disease, Related Dementing Illnesses and Memory Loss Later in Life
  - Nancy L. Mace, M.A. and Peter V. Rabins, M.D., M.P.H. Johns Hopkins Press, 1991M

# DEPRESSION vs DEMENTIA:

- The symptoms of depression and dementia often overlap
- Late life depression can herald impending dementia
- In general, patients with primary depression:
  - Demonstrate ↓ motivation during cognitive testing
  - Express cognitive complaints that exceed measured deficits
  - Maintain language and motor skills

# DEMENTIA vs. DELIRIUM

- Disturbance in consciousness
  - Reduced clarity/awareness of environment
- Change in cognition not accounted for by pre-existing dementia
  - Perceptual disturbance, disorientation, language/memory deficit
- Develops over short period of time (hours to days)
- Caused by physiologic consequence of general medical condition

# Mini-Mental State Exam (MMSE):

- 30-point scale to evaluate orientation, concentration, verbal and visual-spatial skills
- Not necessarily the “gold standard,” but most commonly recognized.
- Subject to level of educational attainment, language barriers, and vision/hearing requirements
- “Early” stages typically score 21-30, “moderate” 11-20, and end-stage 0-10

## Folstein Mini Mental Status Exam

(As modified by Tombaugh & McIntyre, JAGS, September 1992, Vol 40, No. 9)

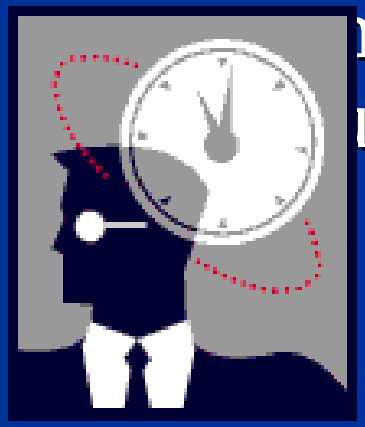
| Area | Max | Task |
|---|---|---|
| Orientation | 5 | What is the year, season, numerical date, day of week, month? |
| | 5 | Where do you live, state, county, town, facility, street? |
| Registration | 3 | Name three objects (apple, penny, table). Patient can repeat accurately. |
| Attention/ Calculation | 5 | Spell world backwards. Or count backward from 100 by 7's (stop after 5 answers) |
| Recall | 3 | Ask patient to remember 3 objects named above (apple, penny, table) |
| Language | 2 | Name pencil/watch |
| | 1 | Repeat: No "ifs, ands, or buts." |
| | 3 | Follow 3-step command |
| | 1 | Read and obey "close your eyes" |
| | 1 | Write a sentence |
| | 1 | Copy interlocking pentagons |

Note: Do both serial 7's and world and use the higher of the 2 scores. Have patient spell world forwards first.

| Score: | | |
|---|---|---|
| | 24-30 | No cognitive impairment |
| | 18-23 | Mild cognitive impairment |
| | 0-17 | Severe cognitive impairment |

# Clock Draw Test

- Instructions:
  - “Draw the face of a clock, putting the numbers in correct position.  I’ll then ask you to indicate a time after you are done.”
  - Ask the patient to draw in the hands at
    minutes after eleven or twenty
    utes after eight.



# Clock Draw Test

- Scoring:
  - Draws closed circle: 1 point
  - Places numbers in correct position: 1 point
  - Includes all 12 correct numbers: 1 point
  - Places hands in correct position: 1 point
- Interpretation:
  - Clinical judgment MUST be applied
  - Cognitively impaired people typically don’t draw a perfect clock

# Clock Draw Examples:


| A | B | C | D | E |
|---|---|---|---|---|
| CDT | CDT | CDT | CDT | CDT |
| 4 | 2 | 2 | 1 | 2 |
| MMSE | MMSE | MMSE | MMSE | MMSE |
| 30 | 20 | 19 | 14 | 19 |

**Figure:** Examples of clock drawing by a normal elderly control (A) and patients with dementia (B-E). For these examples, patients were instructed to draw in the hands at twenty minutes after eight. Respective CDT and MMSE scores are shown below each drawing.[4]

# Dementia treatment and management

- Primary goals:
  - To enhance quality of life
  - Maximize functional performance by improving
    - Cognition
    - Mood
    - Behavior
- Pharmacologic
  - Cholinesterase inhibitors (Aricept, others)
  - NMDA receptor blockers (Memantine)
  - Antipsychotics
- Non-pharmacologic
  - Driving
  - Advanced Directives and Durable Power of Attorney
- Caregiver
- Social and Community

# Pharmacotherapy


MCI

Cognitive Benefit?

Early Dementia

Benefits Cognition

Moderate Dementia

Benefits:
Cognition
Global status
ADLS
Behavior?

Severe Dementia

Benefits:
Global Status
ADLs
Behavior?

# Nonpharmacologic Interventions

- Sensory
  - Music
  - Message/touch
  - White noise
  - Sensory stimulation
- Social Contact
  - One-on-One interaction
  - Pet visits
  - Simulated presence therapy and videos
- Behavior Therapy
  - Differential reinforcement
  - Cognitive behavioral therapy
  - Stimulus control
- Staff Training
- Activities
  - Structured
  - Outdoor walks
  - Physical activities
- Environmental interventions
  - Wandering areas
  - Natural/enhanced environments
  - Reduced-stimulation environments
- Medical/nursing care interventions
  - Light/sleep therapy
  - Pain management
  - Hearing aids
  - Removal of restraints
- Combination therapies

# Dosing Characteristics

| Characteristic | Donepezil | Rivastigmine | Galantamine | Galantamine ER |
|---|---|---|---|---|
| Doses/day | 1 | 2 | 2 | 1 |
| Initial dose (mg/day) | 5 | 3 | 4 | 8 |
| Dose escalation | 4-6 weeks | 2 weeks | 4 weeks | 4 weeks |
| Clinically effective dose | 5-10mg/day | 6-12mg/day | 16-24mg/day | 16-24mg/day |
| Given with food | With/without | With | Recommended | Recommended |

1999

1967-2000

# Demonstration

# Role Play and Clinical Scenario

# Problem List

# Goals for Mental Status Assessment Interaction

- Garner patient's understanding of memory problem
- Introduce pt to concept of performing a mental status exam
- Conduct MMSE and Clock Draw Test
- Respond to patient's questions on results of testing

# Mood and Behavioral Assessment

# TRUE statements regarding late-life depression include

A. Depression is present in 17-37% of PC patients
B. Recurrence of depression is uncommon
C. Medical co-morbidites are common
D. A and C
E. A, B, and C

# Depression evaluation in elderly includes:

A. Eval. of substance abuse
B. Eval. of medications and co-morbidities
C. Eval. of cognitive impairment and impairment
D. Labs of TSH, CBC, US, chem, B12, and med levels
E. All of the above

# True statements regarding late life depression include

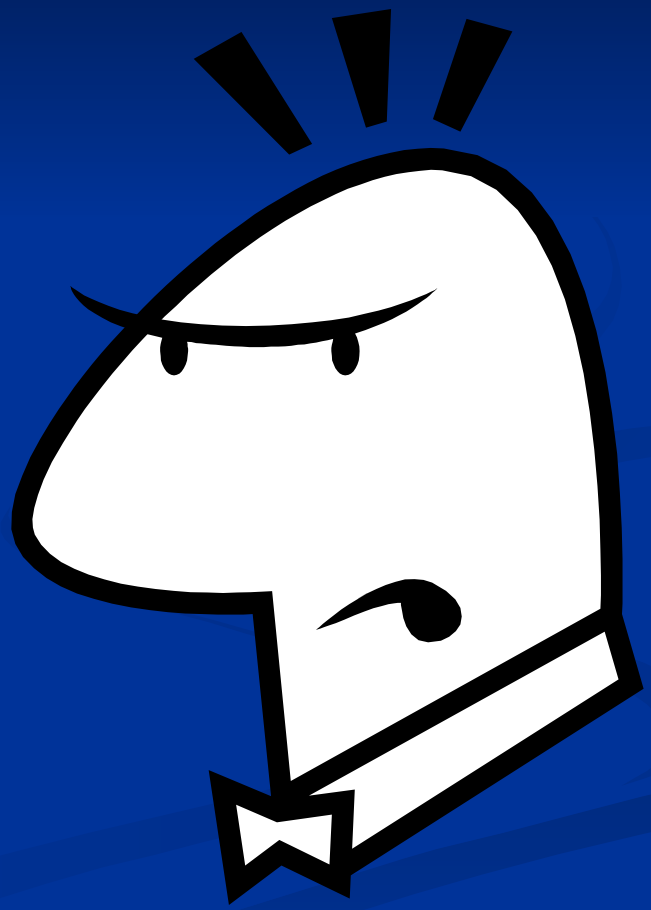
A. Depression is a normal part of aging
B. Elderly pts. reliably report mood changes
C. Treatment effectiveness is less
D. B and C
E. None of the above

# Potential Losses in Older Patients:

- Loss of social role (retirement)
- Loss of family and friends
- Loss of self-image
- Loss of income
- Loss of autonomy and independence
- **Depression is NOT a normal part of aging**

# Depression:

- Source of distress and suffering
- Increased morbidity and mortality
- Increased health care utilization
- Increased risk of suicide
- Under-diagnosed and therefore
- UNTREATED



# Differential Diagnosis:

- Medical conditions
  - Thyroid disease
  - Illnesses resulting in apathy
  - Iatrogenic
- Dementia
  - Decreased concentration
  - Loss of motivation
  - Psychomotor retardation
  - Sleep disturbance
- Bereavement
  - Usually less than 2 months
  - No functional impairment

# 15-Item Geriatric Depression Screen:

1. *Are you basically satisfied with your life?
2. Have you dropped many of your activities and interests?
3. Do you feel that your life is empty?
4. *Do you often get bored?
5. Are you in good spirits most of the time?

Yesavage JA. J Psych Res. 1983; 17: 37-49.

# 15-Item Geriatric Depression Screen

6. Are you afraid something is going to happen to you?
7. Do you feel happy most of the time?
8. *Do you feel helpless?
9. *Do you prefer to stay at home, rather than go out and do new things?
10. Do you feel you have more problems than most people?

# 15 Item Geriatric Depression Screen

11. Do you feel it is wonderful to be alive now?
12. *Do you feel pretty worthless the way you are now?
13. Do you feel full of energy?
14. Do you feel your situation is hopeless?
15. Do you think most people are better off than you are?

# Scoring:

- Count “depressed” responses
- Normal is 0-5
- Greater than 5 suggests depression
- Any one of the (*) items suggests depression (Five item screen)

# Biopsychosocial Treatments:

- Resist reflex of writing for benzos in anxiety disorders
- SSRIs generally well-tolerated
- Counseling and social support is effective
- Education for patient
- Caregiver education and support
- Support groups

# Demonstration

# Goals for the Mood Assessment Interaction

- Understand patient's self description of their mood
- Introduce concept of performing a formal depression screen
- Conduct the Geriatric Depression Screen
- Respond to patient's questions regarding results of the test

# Frailty and Failure to Thrive

# Failure to Thrive is a geriatric syndrome associated with

A. Depression
B. Cognitive Impairment
C. Malnutrition
D. Functional Impairment
E. All of the above

# Markers of malnutrition in the elderly include

A. Low BMI
B. Hypocholesterolemia
C. Hypoalbuminemia
D. Decreased total lymphocyte count
E. B, C, and D

# Initial treatment of geriatric malnutrition includes

A. Multi-disciplinary care
B. Supplements with meals
C. Improving food palatability
D. A and C
E. All of the above

# Functional assessment of the elderly includes

A. Assessment of Activities of Daily Living
B. Assess Instrumental ADLs
C. Assessment of vision, hearing, neurologic, musculoskeletal and social conditions
D. All of the above

# Goals for Frailty/ Failure to Thrive

- Understand patient's self description of their mobility and impairments
- Introduce concept of screening for frailty
- Demonstrate the:
  - Mini Nutritional Screen
  - ADL and IADL Screening
  - Tinetti Balance and Gait Screen
- Student conducts the
  - Timed UP and GO
  - Standing Reach
  - Shampoo and Socks Test
- Respond to patient's questions regarding results of the test

# Components of Frailty and Failure to Thrive

- Cognitive impairment
- Depression (or possibly behavioral)
- Malnutrition
- Functional limitations

# Malnutrition

# Nutrition Screen

- Historical
  - Weight loss
    - 10 pounds/ 6 months
    - 4% over one year
  - Decline in food intake?
    - Appetite decrease
    - GI problems
    - Chew/swallow problems
  - Mobility?
    - Bed bound
    - Getting “out” or not?
  - Recent psychological stress or acute illness?
  - Neuropsychological disorder (i.e., dementia?)
- Laboratory Findings
  - Abnormal BMI
    - <23 or >27
  - Hypoalbuminemia
    - < 3.8 gm/dL
  - Hypocholesterolemia
    - <160 mg/dL)
  - Total Lymphocyte Count
    - Less than 1400
  - Specific vitamin / micro-nutrient deficiency

# Demonstration with patient

# Functional Limitations

# Functional Assessment

- ADL/IADLs
- Gait
- Balance (Dynamic and Static)
- Functional Strength
- Functional Range of Motion

# ADLs and IADLs

- ADL (Activities of Daily Living)
  - Bathing
  - Dressing
  - Toileting
  - Transferring
  - Continence
  - Feeding
- IADLs (Instrumental Activities of Daily Living)
  - Telephone
  - Shopping
  - Food preparation
  - Housekeeping
  - Laundry
  - Transportation
  - Medications
  - Finances

# Demonstration with patient

# Gait

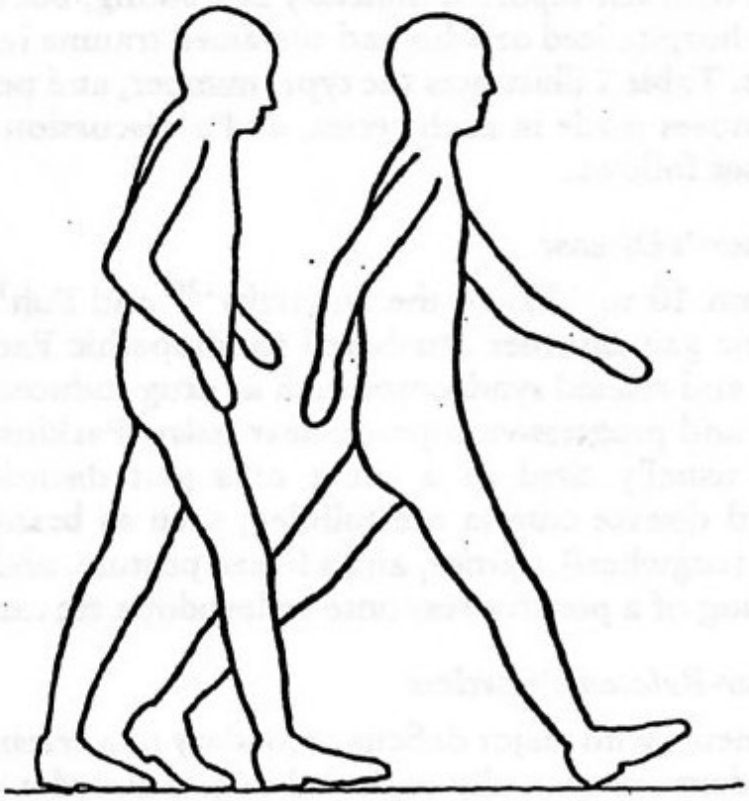


Figure 3. Apparent age-related differences in sagittal body position of healthy old (left) and young (right) men at the instant of heel strike[48] (reprinted with permission).

Alexander N. JAGS. 1996. 44: 434-451.

# Falls (a definition)

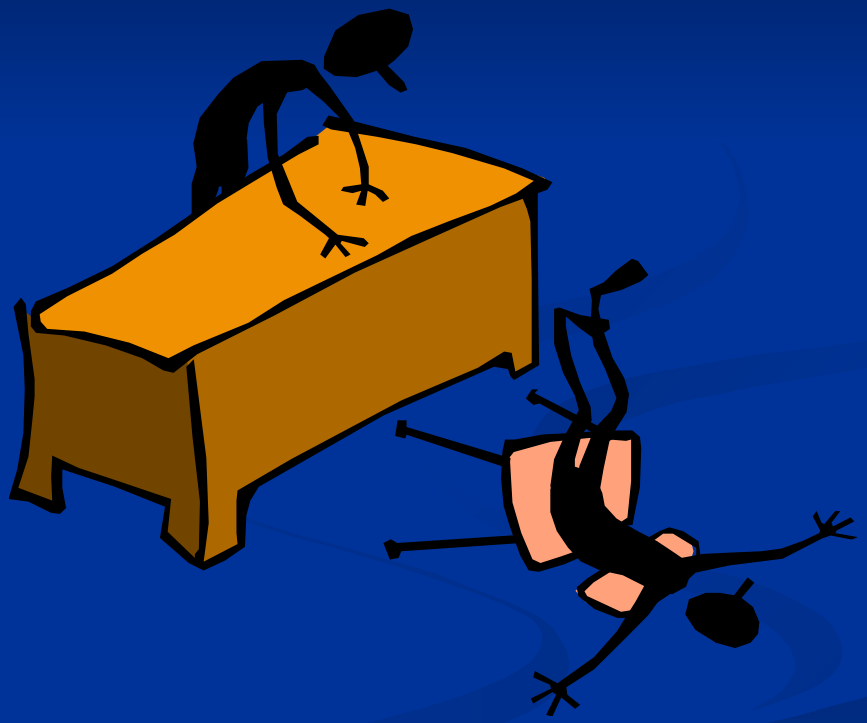
- Fall: Unintentional change in position, coming to rest on the ground or other lower level and not due to an overwhelming intrinsic or environmental cause

- Stumble?
- Trip?
- Unsteady?
- Wobbly?

# Falls are a common occurrence

- Each year, 1/3 of community-dwelling older persons fall

- More than half of nursing home residents fall



# Common Cause of M & M

Morbidity:

- Injuries:  3-5% fractures, 5-10% are soft tissue injuries
- “Long lies”: 40-50% unable to get up
- Quality of life: fear of falling

Mortality:

- Sixth leading cause of death in the elderly
- 70% of all deaths due to falls occurring in the 12% of the population age 65 and older

# Risk Factors

Intrinsic:

- Age
- Sensory impairment
- Cognitive impairment
- Medications
- Postural hypotension
- Gait/Neurologic disorders

Extrinsic:

- Activity level
- Environment: bathroom, bedroom, stairs, clutter, rugs, poor lighting, clothing

# Evaluation by History

- History: previous fall injury is the single most powerful risk factor for serious fall injury
- Determine circumstances preceding the fall (activity, location , time of day)

# Evaluation by Physical Exam

- Postural vital signs
- Visual Acuity
- Strength, reflexes, coordination, sensation
- Foot examination
- Laboratory studies as indicated

# Demonstration of Gait/Balance, TUG, Standing Reach, and “Shampoo and Socks” Screening

# Rehabilitative Interventions

Physical Therapy:

- Transfer, gait and balance training
- Strength and range of motion
- Habituation exercises for vestibular problems
- Proper assistive equipment for ambulation

Occupational Therapy:

- Instruction in safe and effective performance of ADLs/IADLs
- Adaptive equipment
- Home equipment
- Home safety evaluation

# Treatment: Exercise for Elderly Adults

- A reduction in the adjusted fall incidence ratio:

--10% for studies that included endurance, resistance and flexibility exercise programs

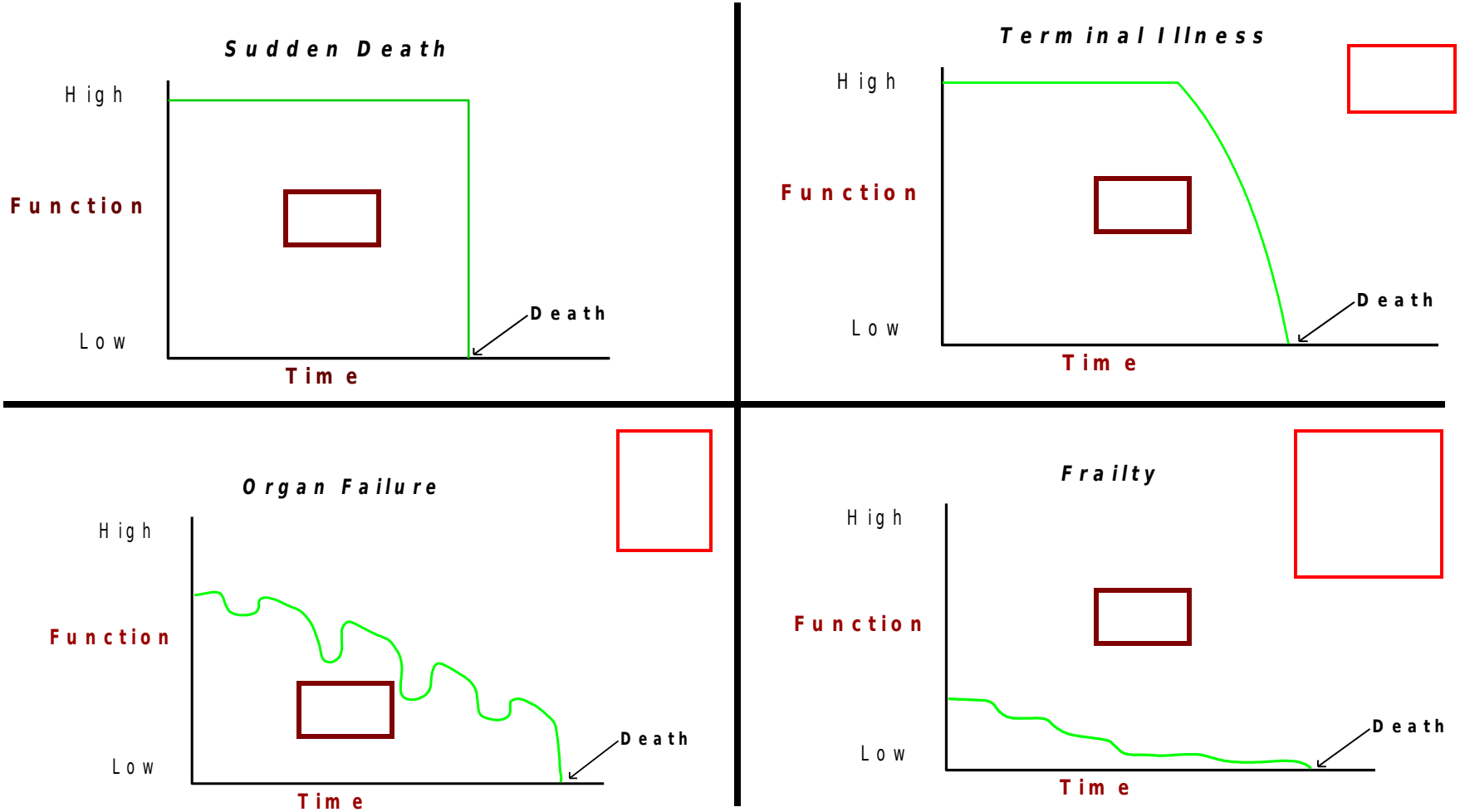
--17%-48% for those that used balance training (Tai Chi)

--An interdisciplinary approach to this high risk population can significantly reduce falls in up to 30% of elderly persons in the community

# Student Practice for the Timed Up and GO, Standing Reach, and Shampoo and Socks Screen

# Conclusions

# Trajectories of Dying




Lunney, JR, Lynn J, Hogan, C. Profiles of Older Medicare Decedents. JAGS 50:1108-1112, 2002

# Dementia Summary

- Dementia is common in older adults but is NOT an inherent part of aging
- AD is the most common type of dementia, followed by vascular dementia and dementia with Lewy bodies
- Evaluation includes history with informant, physical & functional assessment, focused labs, & possibly brain imaging

# Depression Summary

- Primary treatment goals:
  - Enhance quality of life,
  - Maximize function by improving cognition, mood, behavior
- Treatment may use both medications and nonpharmacologic interventions
- Community resources should be used to support patient, family, caregivers

# Frailty and Failure to Thrive

- Functional impairment and malnutrition are common, morbid and costly
- Combined with cognitive impairment and depression (or behavior change) creates Failure to Thrive
- An individualized, multi-factorial intervention is the best approach
- Promote mobility and avoid immobility; minimize medications

# Breaking the Bad News

Anosognosia

# Seminar Summary:

- To preserve independence and function
- To alleviate pain and reduce suffering
- To first do no harm
  - We must understand the cognition of the aged individual
  - We must optimize their function
  - We must treat their minds as well as their bodies

# Question 1

- You discover that a 66-year-old man with prostatic hyperplasia has major depression. He has previously complained of intermittent sexual dysfunction.
- What would be desirable qualities in a medication or therapy?

# Care Study 1

- A 77-year-old woman who lives alone has lost interest in her affairs since her husband of 52 years died suddenly 3 months ago. She says she feels devastated by his death, cries frequently, and has been unable to sleep. She has lost 9 kg (20 lb) in the past 3 months. She feels guilty about the past and hopeless about the future and says she wishes she could “join him.” She had a “nervous breakdown” when she was in her 30s but has otherwise been healthy. On examination, she appears to move and think slowly and has considerable delay in responding to questions. Which of the following is the most likely diagnosis?

# Case Study 1

0%
0%
0%
0%
0%

1. Adjustment disorder with depressed mood
2. Bereavement
3. Major depressive disorder
4. “Masked” depression
5. Mood disorder due to a general medical condition

# Care Study 2

- A 68-year-old widowed man accompanied by his daughter presents for his yearly check-up. He says he is feeling “fine,” but his daughter reports that he has not been sleeping well, has a decreased appetite, and appears “gloomy” and anxious. He says he’s never been depressed before and doesn’t think he is depressed now. He lives alone, prides himself on being independent, and takes care of all his affairs himself. He walks two miles a day and plays bridge with nearby friends. He has a nightcap of bourbon and water every night, but says he’s been doing this all his life and sees no harm in continuing.
- Discussion?

# Care Study 2

- On examination the patient appears to be cognitively intact. He scores 28/30 on the Mini–Mental State Examination and 24/30 on the Geriatric Depression Scale.
- What is the best course of action in managing this patient?

# Case Study 2

0%
0%
0%
0%

1. Electroconvulsive Therapy (ECT)
2. Administer a tricyclic antidepressant
3. Administer a selective serotonin reuptake inhibitor
4. Administer a benzodiazepine

# Care Study 3

- An 80-year-old man is brought to the physician by his daughter because he seems depressed. She says that although he is not sad or tearful, he seems apathetic and uninterested, has difficulty thinking and concentrating, has decreased energy, and appears to have slowed down. There have been no changes in his appetite or sleep pattern. On evaluation, he does not express feelings of worthlessness or hopelessness or have suicidal ideation. He denies all affective symptoms such as tearfulness, loss of energy, or depression.

# Care Study 3

- His score on the Mini–Mental State Examination is 17/30, and his score on the Geriatric Depression Scale is 1/15.
- Which of the following is the most likely diagnosis?

# Care Study 3

0% 1. Dementia of the Alzheimer's type

0% 2. Dementia with depressed mood

0% 3. Major Depressive disorder

0% 4. "Masked" Depression

# Care Study 4

- A 67-year-old retired teacher with advancing Parkinson's disease complains to his primary care physician of intermittent lightheadedness, shortness of breath, palpitations, and chest pain. These episodes have been happening mostly in public places when he is socializing with his wife. They have not happened at home. He reports that he is now mostly staying at home and not exerting himself, as he is fearful of these episodes. There have been no recent changes in his medications. Findings on history and physical examination are otherwise unremarkable. Electrocardiogram is normal.
- What is the most appropriate next diagnostic step?

# Care Study 4

0%
0%
0%
0%

1. Obtain thyroid function studies
2. Assess the situational nature of his symptoms
3. Perform a sleep study
4. Obtain a 24-hour Holter monitor

# Care Study 5

- A 72-year-old man who suffered a posterior right-sided stroke is admitted for rehabilitation at a skilled nursing facility. He participates poorly in therapies and repeatedly brings up multiple medical concerns to his treatment team. He complains of insomnia, his mind going blank, excessive sweating, muscle aches, palpitations, and shortness of breath. He denies feeling sad or pessimistic or wanting to die. He has difficulty in falling asleep but once asleep rests well. He wants to return home and understands the importance of rehabilitation in reaching that goal.
- What is the most likely diagnosis?

# Care Study 5

0%
1. Mood disorder due to a general medical condition

0%
2. Anxiety disorder due to a general medical condition

0%
3. Hypochondriasis

0%
4. Adjustment disorder

0%
5. Delirium

# Care Study 6

- A 74-year-old woman reports insomnia, anxiety, irritability, jitteriness, and motor restlessness. Mood is unaffected, and she has not lost interest in her usual activities. The patient has no history of alcohol or drug use. Review of systems is unremarkable except for increased postprandial and daytime heartburn, for which she has been taking famotidine and metoclopramide for several months. Which of the following is the most appropriate initial step in treating this patient?

# Care Study 6

- Discontinue famotidine
- Discontinue metoclopramide
- Begin buspirone
- Begin diphenhydramine
- Begin lorazepam

# Which anxiety disorder is most prevalent in the elderly age group?

0% Panic disorder

0% Phobic disorder

0% Generalized Anxiety Disorde

0% PTSD

0% OCD (Obsessive Compulsive DO)

# Answer:

- Which anxiety disorder is most prevalent in the elderly age group?
  - Panic disorder
  - ***Phobic disorder***
  - Generalized Anxiety Disorder
  - ***PTSD***
    - ***Remember the unique population you serve***
  - OCD (Obsessive Compulsive Disorder)